**[IN ACCORDANCE WITH CIC SECTION 12938,
THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE CDI WEBSITE]**

WEBSITE PUBLISHED REPORT OF THE MARKET CONDUCT EXAMINATION OF

NEW YORK LIFE INSURANCE COMPANY
NAIC # 66915 CDI # 0139-6

NEW YORK LIFE INSURANCE & ANNUITY CORPORATION
NAIC # 91596 CDI # 2448-9

NYLIFE INSURANCE COMPANY OF ARIZONA
NAIC# 81353 CDI# 3249-0

AS OF DECEMBER 31, 2007

ADOPTED ON DECEMBER 4, 2008

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

Format 12938

NOTICE REGARDING CONFIDENTIALITY

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. Section 12938 of the California Insurance Code requires the publication of certain legal documents and examination reports.

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DEPARTMENT OF INSURANCE
Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013

December 4, 2008

The Honorable Steve Poizner
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims practices and procedures in California of:

New York Life Insurance Company
NAIC # 66915

New York Life Insurance & Annuity Corporation
NAIC # 91596

NYLife Insurance Company of Arizona
NAIC# 81353

Group NAIC # 0826

Hereinafter, the Companies listed above also will be referred to as NYLIC, NYLIAC, NYLAZ, or the Company or, collectively, as the Companies.

This report is made available for public inspection and is published on the California Department of Insurance web site (www.insurance.ca.gov) pursuant to California Insurance Code section 12938.

FOREWORD

The examination covered the claims handling practices of the aforementioned Companies during the period January 1, 2007, through December 31, 2007. The examination was made to discover, in general, if these and other operating procedures of the Companies conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. Violations of other relevant laws were not found in this examination.

The report is written in a "report by exception" format. The report does not present a comprehensive overview of the subject insurer's practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer's proposals for correcting the deficiencies. When a violation that resulted in an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Companies' responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Companies for use in California including any documentation maintained by the Companies in support of positions or interpretations of fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about these Companies handled by the CDI during the same time period/calendar year 2007; and a review of previous CDI market conduct claims examination reports on these Companies; and a review of prior enforcement actions.

4. A review of electronic paid claims data. The analysis however, was limited to a review of timely payment of claims.

The review of the sample of claims files and policies was conducted at the offices of the Companies in New York City, New York. The review of electronic paid claims data was conducted primarily within the office of the Department of Insurance in Los Angeles, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The claims/policies reviewed were closed between January 1, 2007 and December 31, 2007, referred to as the “review period”. The examiners randomly selected 111 NYLIC long-term care policies. On Life Paid claims, the examiners conducted an electronic file review of the entire population claims consisting of 6,890 NYLIC claims, 495 NYLIAC claims, and 35 NYLAZ claims. The examiners also reviewed all denied claims consisting of 16 NYLIC claims and 2 NYLIAC claims for examination. The examiners cited 179 alleged claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 from this sample and electronic file review.

Within the scope of this report, findings in this examination included: failure to provide an explanation of benefits, attempting to settle a claim by making a settlement offer that was unreasonably low, failure to provide written basis for the denial of a claim, failure to include a statement in the claim denial to the claimant advising that he or she may have the matter reviewed by the California Department of Insurance, failure to acknowledge notice of claim within regulatory timeframe requirement, failure to provide written notice every 30 calendar days when additional time was required to determine whether a claim should be accepted or denied and failure to adopt and implement reasonable standards for the prompt investigation and processing of claims.

RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, AND PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT ACTIONS

Except as noted below, market analysis did not identify any specific issues of concern.

The Companies were the subject of 10 consumer complaints and inquiries between January 1, 2007 and December 31, 2007, in regard to the lines of business reviewed in this examination. Six of the 10 complaints fell into the Individual Life category, three were into the Accident and Health (Individual), and one was into Accident and Health (Group). There was no specific area of concern identified in the complaint review.

The previous claims examination reviewed a period from January 1, 1998 through December 31, 1998. There was no specific area of concern identified in the previous claims examination.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

NYLIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	**POPULATION FOR REVIEW PERIOD**	**SAMPLES FOR REVIEW PERIOD**	**CITATIONS**
Accident and Disability/ INDIVIDUAL Long-Term Care Policies	148 Policies 891 Claims	66 Policies 509 Claims Reviewed	110
Accident and Disability/ GROUP Long-Term Care Policies	78 Policies 498 Claims	45 Policies 363 Claims Reviewed	63
TOTALS	226 Policies 1,389 Claims	111 Policies 872 Claims Reviewed	173

NYLIC SAMPLE FILES REVIEW			
LINE OF BUSINESS/CATEGORY	**CLAIMS IN REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**CITATIONS**
LIFE/ Individual Life (Denied Claims)	16	16	6
LIFE/ Individual Life (Paid-Electronic Review)	6,890	6,890	0
TOTALS	6,906	6,906	6

NYLIAC SAMPLE FILES REVIEW			
LINE OF BUSINESS/CATEGORY	**CLAIMS IN REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**CITATIONS**
LIFE/ Individual Life (Denied Claims)	2	2	0
LIFE/ Individual Life (Paid –Electronic Review)	495	495	0
TOTALS	497	497	0

NYLAZ SAMPLE FILES REVIEW			
LINE OF BUSINESS/CATEGORY	**CLAIMS IN REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**CITATIONS**
LIFE/ Individual Life (Denied Claims)	0	0	0
LIFE/ Individual Life (Paid –Electronic Review)	35	35	0
TOTALS	35	35	0

TABLE OF TOTAL CITATIONS

Citation	Description	NYLIC	NYLIAC	NYLAZ
CCR §2695.11(b)	The Company failed to provide an explanation of benefits.	61	0	0
CCR §2695.7(b)(1)	The Company failed to provide the written basis for the denial of the claim.	27	0	0
CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	18	0	0
CCR §2695.5(e)(1)	The Company failed to acknowledge notice of claim within 15 calendar days.	17	0	0
CCR §2695.7(b)(3)	The Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	11	0	0
CCR §2695.7(c)(1)	The Company failed to provide written notice of the need for additional time every 30 calendar days.	10	0	0
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.	10	0	0
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	6	0	0
CCR §2695.5(e)(3)	The Company failed to begin investigation of the claim within 15 calendar days.	4	0	0
CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days.	3	0	0
CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to coverage at issue.	3	0	0
CCR §2695.7(h)	The Company failed, upon acceptance of the claim, to tender payment within 30 calendar days.	2	0	0
CCR §2695.11(a)	The Company improperly sought reimbursement of an overpayment or withheld a portion of a benefit payment.	2	0	0

TABLE OF TOTAL CITATIONS				
Citation	**Description**	**NYLIC**	**NYLIAC**	**NYLAZ**
CCR §2695.3(a)	The Company failed to maintain all documents, notes and work papers in the claim file.	1	0	0
CCR §2695.3(b)(2)	The Company failed to record in the file the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file.	1	0	0
CCR §2695.4(a)	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	1	0	0
CCR §2695.7(b)	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	1	0	0
CCR §2695.7(d)	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation of a claim.	1	0	0
Total Citations		**179**	**0**	**0**

TABLE OF CITATIONS BY LINE OF BUSINESS	
ACCIDENT AND DISABILITY/ INDIVIDUAL LONG-TERM CARE NYLIC 2007 Written Premium: $ 54,893,306 **AMOUNT OF RECOVERIES $9, 357. 32**	**NUMBER OF CITATIONS**
CCR §2695.11(b)	35
CCR §2695.7(b)(1)	26
CCR §2695.7(g)	11
CCR §2695.7(c)(1)	8
CCR §2695.7(b)(3)	6
CIC §790.03(h)(3)	4
CIC §790.03(h)(5)	4
CCR §2695.5(e)(1)	3
CCR §2695.5(b)	3
CCR §2695.5(e)(3)	2
CCR §2695.7(h)	2
CIC §790.03(h)(1)	2
CCR §2695.11(a)	2
CCR §2695.3(a)	1
CCR §2695.7(d)	1
SUBTOTAL	**110**

ACCIDENT AND DISABILITY/ GROUP LONG-TERM CARE NYLIC 2007 Written Premium: $ 54,893,306 **AMOUNT OF RECOVERIES $24,197.22**	**NUMBER OF CITATIONS**
CCR §2695.11(b)	26
CCR §2695.5(e)(1)	14
CCR §2695.7(g)	7
CIC §790.03(h)(3)	5
CIC §790.03(h)(5)	2
CCR §2695.5(e)(3)	2
CCR §2695.7(b)(3)	2
CCR §2695.7(c)(1)	1
CCR §2695.7(b)(1)	1
CIC §790.03(h)(1)	1
CCR §2695.3(b)(2)	1
CCR §2695.4(a)	1
SUBTOTAL	**63**

LIFE/ INDIVIDUAL LIFE (DENIED REVIEW) **NYLIC 2007 Written Premium: $660,162,975** **NYLIAC 2007 Written Premium: $257,074,522** **NYLAZ 2007 Written Premium: $ 14,828,611** **AMOUNT OF RECOVERIES $ 0. 00**	**NUMBER OF CITATIONS**
CCR §2695.7(b)(3)	3
CIC §790.03(h)(3)	1
CCR §2695.7(b)	1
CCR §2695.7(c)(1)	1
SUBTOTAL	**6**

LIFE/ INDIVIDUAL LIFE **(ELECTRONIC PAID REVIEW)** **NYLIC 2007 Written Premium: $660,162,975** **NYLIAC 2007 Written Premium: $257,074,522** **NYLAZ 2007 Written Premium: $ 14,828,611** **AMOUNT OF RECOVERIES $ 0. 00**	**NUMBER OF CITATIONS**
SUBTOTAL	**0**

TOTAL	**179**

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked if it intends to take appropriate corrective action in all jurisdictions where applicable. The Company intends to implement corrective action in all jurisdictions where it is required.

Money recovered within the scope of this report was $33,554.54 as described in sections number 3, 8, and 13 below.

ACCIDENT AND DISABILITY - LONG-TERM CARE (Group and Individual)

1. In 61 instances, the Company failed to provide to the claimant an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits. The Company transmits an Explanation of Benefits (EOB) letter to the policyholder upon claim settlement which is not a clear computation or explanation of benefits. The following EOB deficiencies were noted: The Company references a general range of dates of service instead of the specific or actual dates of service that were paid or denied; daily benefit rate or maximum limits applied were not disclosed; application of inflation benefit riders and/or adjusted inflation rates were not disclosed; description of benefits or coverage upon which payments are made were inaccurate or misleading (i.e. use of Personal Care in lieu of Informal Care); insufficient or incomplete breakdown of how the Company calculated or computed the benefits; overlapping dates of services for one or more coverage were not clarified; and actual billed charges were not correctly reflected on the Explanation of Benefits (EOBs). The Department alleges these acts are in violation of CCR §2695.11(b).

Summary of Company Response: The Company responds that its EOB meets the requirements of CCR §2695.11(b) as it provides information regarding the dates of service, billed amount, provider, amount excluded, amount paid, and other pertinent notations. The Company admits that its EOB may provide dates of service in the form of a date range as indicated from the first date of which there is an eligible charge, and the last date of the invoice. The Company's system has limitations on the length of characters allowed for description on its EOB form. The Company is committed to enhancing its system in order to provide a greater level of service to its customers. The Company has been actively preparing requirements for a new claim system, which would provide greater claim detail and expects the new system to be implemented in 2009. In the interim, the

Company has implemented a manual process to provide additional detail in an explanation of benefits (EOB) letter in the event that the existing fields do not allow for the presentation of sufficient detail.

2. In 27 instances, the Company failed to provide the written basis for the denial of the claim. The Company failed to send a full or partial denial of claims or services presented. The Company did not provide a legal basis for the denial, failed to address the specific charges that are being denied and/or failed to send a denial notice to the insured. The examiners identified the following charges which were not officially denied: nursing supplies, rehabilitation services, linen, furniture rental, salon services, ancillary charges, health and wellness charges, other assisted living services, respite premium or medication services, dates of services considered 'non-eligible' when they were prior to assessment reports, and other dates of service not considered for payment. The Department alleges these acts are in violation of CCR §2695.7(b)(1).

Summary of Company Response: "Due to the extensive irregularity and variances in how long-term care providers bill their clients for services, it is customary for providers to include charges on their invoices for a variety of services that do not pertain to and are not covered by a long-term care insurance policy. To make the reimbursement process as simple as possible for our insureds, the Company accepts copies of these invoices in their original formats and do not require the insureds to restructure the submission of their long-term care invoices or complete separate claim forms for covered services. It is also the Company's experience that policyholders have a reasonable expectation that the various ancillary charges included in their provider invoices, such as cable television services, housekeeping services, linen services, and other supplies, are not being submitted as "claims" under their long-term care policies and therefore no formal "denial" is expected or required. Historically, this subject has not been a source of complaints or consternation from our insureds". The Company also takes the position that dates of services prior to the approved "claim commencement date" or the policy's time limits for filing a claim are not eligible for claim consideration and would not be covered under the policy.

The Department maintains that a written denial is required by regulation as it would be presumptive for the Company to consider the above charges are not covered by the policy. Depending on the policy provision, services such as housekeeping services, ancillary services, respite premium, assisted living services, medication services, and other services may be covered based on policy provisions and benefits. Although the Company does not believe that ancillary charges (e.g., cable television services, housekeeping services, linen services, and other supplies), which do not pertain to long-term care services should be treated as a claim denial, its EOBs will be amended to note that charges for such services were not considered as they are not reimbursable expenses under the insured's policy.

The Company has implemented a manual procedure to provide more information why non-qualifying ancillary charges are not paid. The Company is also actively preparing requirements for a new claim system, which would provide greater claims detail. The Company expects to have this new system implemented during 2009.

3. <u>In 18 instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.</u> The following summarizes the examiners' findings pertinent to the Company's benefit calculation errors:

a) Miscalculation on the number of days under Waiver of Premium (WOP) and incorrect application of the WOP benefits (or premium refund) in three instances;

b) An excessive number of days applied to the elimination period, and/or an improper application of "elimination period days" in three instances;

c) The Company's determination of the "first date of eligibility" is not consistent with the actual eligibility of the insured as supported by factors including the diagnosis, level of care, and health assessment of the insured. This resulted in a wrongful denial and/or non-payment of benefits in three instances;

d) Non-payment of qualified benefits such as bed-hold reservation benefits and the adjusted daily rate for holiday fee in two instances;

e) Wrong daily benefit rates paid resulted in insufficient payments in two instances;

f) Application of a "30-day notice of claim" and a "90-day proof of claim" lookback on eligible claims in two instances;

g) In one instance each (for a total of three) the Company 1) incorrectly paid the tax rate on Durable Medical Equipment (DME) and did not consider other pertinent charges such as shipping, handling and labor charges; 3) failed to adjust for correct benefits during transition from home health care to a higher level of care for skilled nursing benefits; and 4) applied informal care benefits at 50% instead of 100% under home care-based benefits (HCBC).

As a result of these findings, a total amount of $19,705.34 was paid to policyholders/claimants. The Department alleges these acts are in violation of CCR §2695.7(g).

<u>Summary of Company Response:</u> "The Company disagrees with the Department's characterization that the Company attempted to settle claims by making settlement offers that were unreasonably low when we administered these claims. The Company's practice is to pay claims in accordance with the policy provisions, not to make settlement offers for amounts less than the policy benefits. In the instances noted above, errors were made with respect to the processing of these claims; however, the Company certainly did not intend to make settlement offers. These cases were not handled in accordance with Company's procedures as outlined in the Company's Claims Manual. The Company does not believe these unintentional errors should be classified as attempts by the Company to make unreasonably low settlement offers."

These were instances of unintentional errors and the Company issued additional monies in all of the above instances. The Company acknowledges that there were days of

care that were overlooked, and that there were instances wherein an excessive number of days were applied to the elimination period. The Company also agrees that due to human/clerical errors and other isolated oversights, some claims were processed inaccurately. The Company does not have a policy to institute a "30-day" or "90-day" look back when the notice of claim, and/or proof of loss were not submitted in a timely manner. The Company indicates it has a quality assurance program in place as its Actuarial Department audits its claims on a regular basis as part of its ongoing quality control procedure. The Company has addressed these errors with the pertinent staff and will continue to train its personnel for compliance with CCR §2695.7(g). The Company has implemented auditing procedures for the administration of California claims to ensure the accuracy of claim handling. The Company is also actively preparing requirements for a new claim system, which would provide greater claims detail, track time-triggered actionable events and provide required statements for various forms and correspondence. The Company expects to have this new system implemented during 2009.

4. In 17 instances, the Company failed to acknowledge notice of claim within 15 calendar days. The Company receives notices and/or proof of claim that include advance billings for invoices that are not yet qualified for payment until the conclusion of the specified benefit period. Other claims processing activities such as securing updated licenses and /or verification of provider services may also extend the claims processing an average of 40-50 days from receipt of claim. Although invoices for long-term benefits may be recurring on a periodic basis, these invoices are not set up for automated payments and are still subject to the Company's review and approval every time. The Company does not have a procedure in place to acknowledge these claims if payment is not processed within 15 days. The Department alleges these acts are in violation of CCR §2695.5(e)(1).

Summary of Company Response: "It is the Company's position that acknowledgment of claim is made at the time of claim inception only when the Company is first notified to commence the claim process and establish the insured's benefit eligibility. The periodic receipt of invoices on an established claim is not considered a new claim. Rather, such invoices are proof of claim and therefore no acknowledgment is required. The underlying determination of claim eligibility has already been approved or denied. Subsequent submissions of invoices are paid within the time required by California law."

The Company believes it is currently in compliance with CCR §2695.5(e)(1) as it interprets the monthly submission of invoices as proof of claim and not subject to this regulation. However, the Company has implemented new procedures to acknowledge claims when payment has not been issued within 15 days of receipt. The Company has also implemented manual controls to track time-triggered actionable events. The Company is also actively preparing requirements for a new claim system, which would provide greater claims detail, track time-triggered actionable events and provide required statements for various forms and correspondence. The Company expects to have this new system implemented during 2009.

5. In eleven instances, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The Department alleges these acts are in violation of CCR §2695.7(b)(3).

Summary of Company Response: The Company acknowledged these deficiencies. These cases were not handled in accordance with Company's procedures as outlined in the Company's Claims Manual. A template letter has been created with the required language. The Company has reinforced compliance on this issue by conducting training. The Company is also actively preparing requirements for a new claim system, which would provide greater claims detail, track time-triggered actionable events and provide required statements for various forms and correspondence. The Company expects to have this new system implemented during 2009.

6. In nine instances, the Company failed to provide written notice of the need for additional time every 30 calendar days. The Company failed to send regular status letters or requests for extension of time while awaiting additional claim information such as current provider licenses, doctor's statement, provider information, assessment reports, and other pertinent claim documents. The Department alleges these acts are in violation of CCR §2695.7(c)(1).

Summary of Company Response: The Company acknowledged these deficiencies. These cases were not handled in accordance with Company's procedures as outlined in the Company's Claims Manual. The Company has implemented manual controls to track time-triggered actionable events. The Company has reinforced compliance on this issue by conducting training. The Company is also actively preparing requirements for a new claim system, which would provide greater claims detail, track time-triggered actionable events and provide required statements for various forms and correspondence. The Company expects to have this new system implemented during 2009.

7. In nine instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The following summarizes the examiners' findings:

a) Processing errors in the determination of elimination days and the qualified dates of service in two instances;
b) Delay in securing or reviewing current provider licenses in two instances;
c) Delay in processing of a hospice claim in one instance;
d) Failure to recognize respite premium as a qualified benefit under the policy in one instance;
e) Failure to follow Company procedure and verify confinement to process bed-hold benefits in one instance;
f) Failure to explain appropriate assessment procedures which could potentially prejudice the insured's immediate eligibility 'start date' for benefits. The Company also did not secure medical information and other medical records to establish eligibility date from the onset of the claim in one instance.
g) There was an imposed "90-day look back" in determining eligibility of benefits in one instance.

The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of Company Response: This is not the standard practice outlined in the Company's Policies and Procedures Manual regarding the handling of California claims. The Company acknowledges processing errors and non-compliant activities but indicate these are not reflective of the Company's standard procedures and policy. The Company has implemented manual controls to track time-triggered actionable events. The Company has reinforced compliance on this issue by conducting training. The Company is also actively preparing requirements for a new claim system, which would provide greater claims detail, track time-triggered actionable events and provide required statements for various forms and correspondence. The Company expects to have this new system implemented during 2009.

8. In six instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The following summarizes the examiners' findings:

a) No follow-up or investigation on unpaid and/or missing invoices in two instances;

b) Determination of first date of eligibility was in error when the insured had been hospice-certified and was receiving services prior to the Company's approved date;

c) Waiver of premium (WOP) benefit was not applied timely and the WOP refund was delayed for one year;

d) The Company imposed licensure requirements for a provider which is not necessary for the level of care as defined under CIC 10235.2(b) and CIC 10232.9(c) in one instance;

e) The Company considered the "first date of eligibility" for informal care only from the health assessment date of 10/4/06 instead of the actual start date of 9/11/06 when the insured had his first day of care. The Company failed to advise the insured that no benefits will be considered prior to the appointment date, which in effect would prejudice the insured's first eligibility date.

As a result of the above findings, the Company agreed to reopen its claims for consideration of additional benefits and issued a total amount of $13,799.20 to policyholders/claimants. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of Company Response: This is not the standard practice outlined in the Company's Policies and Procedures Manual regarding the handling of California claims. It is the Company's policy to investigate and pay benefits accurately and fairly. These instances were isolated cases and not representative of a pervasive problem.

In light of the concerns raised by the Department regarding the administration of the informal care benefit, the Company enhanced its current claim intake process to provide insureds and their representatives with more detailed information regarding this benefit and explains the need to schedule the assessment as soon as possible in order for the

insured to receive benefits in a timely manner. For our non tax-qualified policies, the Company will consider a Plan of Care from a licensed health care practitioner other than the registered nurse (R.N.) assessor to help establish the date on which benefit eligibility began. For our tax-qualified policies, the Company enhanced its current claim intake process to provide insureds and their representatives with more detailed information regarding the *Advantages of Using the Care Coordinator Benefit* and explains the importance of scheduling the assessment in order to receive benefit payments immediately if the insured is eligible and elects to receive these benefits.

The Company has also implemented manual controls to track time-triggered actionable events. The Company is also actively preparing requirements for a new claim system, which would provide greater claims detail, track time-triggered actionable events and provide required statements for various forms and correspondence. The Company expects to have this new system implemented during 2009.

9. In four instances, the Company failed to begin investigation of the claim within 15 calendar days. In three of these instances, the Company failed to secure an updated provider license in a timely manner. In the last instance, the Company failed to secure medical authorizations, or follow-up on missing information to expedite settlement of the claim. The Department alleges these acts are in violation of CCR §2695.5(e)(3).

Summary of Company Response: It is the Company's policy to investigate and expedite claims promptly. These were not handled in accordance with Company procedures as outlined in the Company's Claims Manual. The Company has implemented manual controls to track time-triggered actionable events and timeliness of handling. The Company has reinforced compliance on this issue with the claims staff. The Company is also actively preparing requirements for a new claim system, which would provide greater claims detail, track time-triggered actionable events and provide required statements for various forms and correspondence. The Company expects to have this new system implemented during 2009.

10. In three instances, the Company failed to respond to communications within 15 calendar days. The Department alleges these acts are in violation of CCR §2695.5(b).

Summary of Company Response: It is the Company's policy to respond to all communications within regulatory timelines. These are isolated instances of non-compliance to the Company's procedure as outlined in the Company's Claims Manual. The Company has implemented manual controls to track time-triggered actionable events. The Company has reinforced compliance on this issue by conducting training. The Company is also actively preparing requirements for a new claim system, which would provide greater claims detail, track time-triggered actionable events and provide required statements for various forms and correspondence. The Company expects to have this new system implemented during 2009.

11. In three instances, the Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. In two instances, the Company misrepresented to the insured that there was no coverage due to an ineligible care provider when the low level of care does not require a home health care

licensing requirement to be under the care of a physician or a nurse. These licensure requirement qualifications were misapplied in these cases. In the third instance, the Company misrepresented policy provisions to an insured in its eligibility/denial letter of August 20, 2007, advising the insured that "we were only allowed to backdate a maximum of 30 days due to the guidelines of the California policy". The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of Company Response: The Company advised that this claim was processed in error as it has no policy in place with a restriction for a 30-day look back on notice requirements. The Company has agreed to conduct a review of all pertinent claims on this policy for eligible claims from October 16, 2006 to June 6, 2006 on this claim. The Company has likewise reopened the two other claims pertinent to the licensing requirement of providers for consideration of additional benefits. The Company paid additional benefits on two of the policies; no additional benefits were due on the other policy. The Company also provided re-training of pertinent claims staff for reinforcement and compliance with CIC §790.03(h)(1). The Company will continue to address this issue through training and auditing controls.

12. In two instances, the Company failed, upon acceptance of the claim, to tender payment within 30 calendar days. The Department alleges these acts are in violation of CCR §2695.7(h).

Summary of Company Response: The Company's standard procedure is to pay claims timely. The Company indicates that these were isolated instances of failure to follow Company procedures as outlined in the Company's Claims Manual. The Company has implemented manual controls to track time-triggered actionable events. The Company has reinforced compliance on this issue by conducting training. The Company is also actively preparing requirements for a new claim system, which would provide greater claims detail, track time-triggered actionable events and provide required statements for various forms and correspondence. The Company expects to have this new system implemented during 2009.

13. In two instances, the Company sought reimbursement of an overpayment or withheld a portion of a benefit on the basis that the sum withheld was an adjustment or correction for an overpayment made on a prior claim. In one instance, the Company issued an Explanation of Benefit reflecting a reduction of benefits due to an overpayment without stating the cause of the error to identify and validate reason for the adjustment. In the second instance, a written authorization was not secured from the insured and the notification was not within the regulatory timeline of 6 months from the date of the error. The Department alleges these acts are in violation of CCR §2695.11(a).

Summary of Company Response: The Company acknowledged these deficiencies. Although the Company's internal file documented the overpayment calculation, the cause and basis of the amount of overpayment was not clearly addressed in its Explanation of Benefits, or communication to the insured. The Company also erred in collecting for the overpayment beyond the 6-month regulatory timeline and therefore issued the $50 in monies back to the insured during the examination.

The Company has reinforced compliance on this issue by conducting training. The Company is also actively preparing requirements for a new claim system, which would provide greater claims detail, track time-triggered actionable events and provide required statements for various forms and correspondence. The Company expects to have this new system implemented during 2009.

14. In one instance each, (for a total of five), the Company a) failed to maintain all documents, notes and work papers in the claim file in violation of CCR §2695.3(a); b) failed to record in the file the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file in violation of CCR §2695.3(b)(2); c) failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy in violation of CCR §2695.4(a); d) failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days in violation of CCR §2695.7(b); and e) failed to conduct and pursue a thorough, fair and objective investigation of a claim in violation of CCR §2695.7(d). The Department alleges these acts are in violation of the Fair Claims Practices Regulations.

Summary of Company Response: The Company acknowledges these findings and indicates that these were isolated instances of failure to follow Company procedures as outlined in the Company's Claims Manual. The Company addressed these deficiencies with pertinent claims staff by additional training and reinforcement of appropriate procedures. The Company has implemented a process for supplying all claimants with a duplicate copy of their policy, and manual controls to track time-triggered actionable events. The Company is actively preparing requirements for a new claims system, which would provide greater claims detail, track time-triggered actionable events and provide required statements for various forms and correspondence. This new system will be implemented in 2009.

INDIVIDUAL LIFE (DENIED CLAIMS)

15. In three instances, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The Department alleges these acts are in violation of CCR §2695.7(b)(3).

Summary of Company Response: The Company acknowledges these findings and indicates that these instances are isolated incidents and is not representative of a pervasive problem. The Company sent a written reminder of the requirements under CCR §2695.7(b)(3) to all claims analysts on April 10, 2008. This subject will also be an area of focus for the 2008 California Fair Claims Practices training of the Company.

16. In one instance, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Company failed to investigate and process a claim promptly. The investigation was extended over eight months ultimately resulting in a policy rescission when documentation was provided four months earlier. The Department alleges this act are in violation of CIC §790.03(h)(3).

Summary of Company Response: The Company acknowledges that while the review of this claim took longer than anticipated and communications with the claimant should have been more frequent, the circumstances of this claim are not representative of the standard procedure of the Company. Compliance to CIC §790.03(h)(3) will be one of the focus items in the Company's upcoming 2008 California Fair Claims Practices regulations.

17. In one instance each (for a total of two), the Company a) failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days, in violation of CCR §2695.7(b), and b) failed to provide written notice of the need for additional time or information every 30 calendar days in violation of CCR §2695.7(c)(1). The Department alleges these acts are in violation of Fair Claims Practices Regulations.

Summary of Company Response: The Company acknowledges these findings and indicates that these were isolated instances of failure to follow Company procedures and regulations. While these omissions are not representative of a pervasive problem, the Company will include these regulations as an area of focus in the 2008 California Fair Claims Practices training scheduled later this year.

INDIVIDUAL LIFE (ELECTRONIC REVIEW of LIFE PAID CLAIMS)

The Department conducted an electronic review of all "paid" life claims closed within the window period. The scope was limited to the Company's payment of interest on claims paid beyond 30 days from the date of death or occurrence. From this electronic population, five claims were manually reviewed for validation purposes and did not disclose any deficiencies.

There were no citations or criticisms of insurer practices made within the scope of this electronic review. There were no recoveries discovered within the scope of this electronic review.